The oral presentation: An overview

During your month on inpatient family medicine you will be required to master 3 distinct types of oral presentations. These are distinct from the written H&P. Oral presentations and written H&Ps (or consult notes, etc) are different and serve different purposes. The written H&P serves as a permanent record of ALL information relating to a patient. It will always include more detail than any oral presentation. (For example: all written H&Ps will include a full 12 system ROS, a detailed PE, a full social hx, etc). The purpose of each of the oral presentations below is to tell a good story. Consider your audience prior to the presentation, and think about what it is that your listener most needs to know at the end of your presentation. Of all the skills learned during your time on inpatient family medicine, effective communication is one of the most critical. Being a successful family physician requires good oral presentation skills, and this overview is meant to help "set the stage" for a successful month.

The three types of oral presentations are:
1. **The "bedside" presentation** (to be used in family-centered rounding)
2. **The "table" presentation** (presentation to team/faculty)
3. **The "faculty checkout" presentation** (also used in discussions with faculty)

The "bedside" presentation (Patient and Family Centered Rounding):

This oral presentation serves to convey information to a diverse group of listeners and is thus, the most challenging form of the oral presentation. Families have diverse understandings of healthcare and disease processes, and one of the goals of this type of rounds is to increase the understanding of patients and families. The bedside presentation also establishes rapport with the pt/family and the team, letting them know that their story was heard and that you, the presenter, are *their* doctor. Hence, medical jargon must be avoided and terms and relevant labs should be explained. The desire for this oral presentation type to both increase family/patient knowledge must be tempered with the need for them to also convey meaningful information to team members and attending physicians. Some things to keep in mind:

- 5-7 minutes in most situations (note: as with all types of oral presentations, this requires some forethought and possibly practice initially)
- Explain the process in the ED at the time of admission: a sample phrase: "We round in a different way here. We have found that partnership and communication is really important, and while we are the experts on medicine, you are the expert on YOU, and together we can take better care of you. With your permission, we will present relevant information to you and any family members you want in attendance. This also helps our whole team all know your story, since we will hear it and review it all together. There may be some discussion, but I will always explain everything we are talking about. Sound okay?"
- The presentation is still a presentation, not a dialog. The history has already been gathered. Resist the urge to re-ask question. ("You take metformin, right?")

- Avoid medical jargon: explain terms (i.e. no need to use the word “tachypnea” if that is what the PMD noted, when you can say “breathing fast”)
- For labs and imaging: give the pt/family permission to “tune out”: “I am going to review the labs and imaging: I will translate and fill you in at the end”
- This type of oral presentation contains KEY elements of the HPI/PMHx/Fam/Soc/PE, etc. (the fact that they finished high school only, or that their mother died of a stroke at age 91 is likely NOT relevant and should be omitted: it WILL be present in your written H&P, obviously)
- Use the pronoun “you” and “your” instead of “he/she” to draw in your listeners.
- This presentation type moves quickly from area to area
- It contains a STRONG and brief assessment statement
- Following the Plan section, a distinct “Plan for the Day” should be presented, letting them know what the key tests, goals, things they have to do, etc are.
- Pt/family then asked for questions
- Senior/attendings then asked for questions

<u>The Table Presentation</u>

- 5-7 minutes, depending on complexity
- Medical jargon useful to condense: don’t use 5 words if you can say it in 3
- A highly edited HPI is critical to a successful presentation (while in the written H&P lots of detail might be needed, in the “table” presentation it might suffice to say: “this 57y/o was admitted with worsening dyspnea over 2 weeks with worsened orthopnea and cough for 3 days.”
- If the PMHx is mentioned in the HPI (a 57y/o with a PMHx of…) then only relevant issues should be listed. Gout and Macular Degeneration are likely *not* needed here.
- A complete PMHx is almost always appropriate: just move through it rapidly!
- Only relevant parts of the Social/Fam Hx should be included. (if someone has concerns about a specific bird-borne illness and are wondering about pets, we can ask after the presentation)
- PE: report the range of vitals and general appearance (not needed in bedside rounds unless it was very different at the time of the admission)
- Proceeds rapidly from section to section, telling a story and building a case for the management decisions presented in the plan section
- Please include a strong “1 liner” in the assessment
- The plan should progress from most critical to least critical issues and conclude with questions for the attending

<u>The Faculty Checkout Presentation:</u>

- Used for patients admitted overnight who are being “picked up” by the faculty service (also very useful for calling consults and briefly explaining the details of the case)
- 1-2 minutes, sometimes less
- Only the most critical issues in the case are presented
- Contains a brief and focused HPI that might include all other relevant historical elements

- Less is more!
- Short enough to not need an assessment
- Plan limited to only the most critical/relevant issues and/or questions for the consultant
- *Example: "This 57y/o AAM with a history of CAD and an EF of 25% in '09 has had 2 weeks of DOE with 3d of orthopnea and a NP cough. No fevers. He is very compliant with his cardiac medications, which include Lasix 20 BID, lisinopril, Coreg, Lipitor, and ASA. He lives alone (relevant for DC planning needs). His vitals were: 166-192/88-102, 88-102, 14-20, 94% 4lpm by NC, weight was 208 lbs, up 12 lbs from '09. He appeared mildly dyspneic, had JVD to the jaw, rales, and 2+LE edema. EKG showed NSR with an old LBBB, CXR showed congestion, Na+ was 128, Cr 1.8, which is up 0.4-0.6, and Hgb was 10. Cardiac enzymes negative. I admitted him to Tele and he is feeling less dyspneic after 1.25 of Vasotec IV, nitropaste, and 80mg Lasix IV x2 overnight. His enzymes remain negative, and he has an echo pending."*